



Department of Health and Human Services
Maine Center for Disease Control and Prevention
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MONTHLY CREMATORIUM REPORT

Please complete all of the following data components. Please print legibly or type.

FACILITY INFORMATION

Facility Name: _____
Facility Location, Street: _____
Facility Location, Town/City: _____
Facility Mailing Address: _____
Facility Operator/Authority: _____
Telephone: _____ E-mail: _____

OPERATIONS SUMMARY

1. Reporting Period: Month ending on (MM/DD/YYYY) _____
2. During this reporting period, the subject facility cremated the remains of _____ persons.

I, _____, Facility Operator/Authority for the subject facility, hereby state that this report is
Print Your Name

accurate to the best of my knowledge. I further stipulate that I am aware that deliberate falsification of the information herein shall be sufficient cause for an audit of the subject facility's records.

Signature of Facility Operator/Authority

Date

HHE-***, Rev. **/09